Primary Applicant Name_____
Enrollment Form ID_____

Cigna Health and Life Insurance Company

Maryland Individual and Family Plan Enrollment Application / Change Form
900 Cottage Grove Road, Bloomfield, CT 06002

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ Child(ren) Only

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change

Subscriber Name:_____ Subscriber ID:_____

Requested Effective Date:*
☐ 1st of the Month of_____

Effective dates are assigned to the 1st of the month. Cigna Health and Life Insurance Company will assign the next available effective date if not selected by the applicant.

** Requested Effective Date cannot be greater than 60 days after the Signature Date. No Effective Dates will be assigned prior to or on the Signature Date.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or within 60 calendar days of a qualifying event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the qualifying event below)*. Qualifying events **do not** include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission under federal law.

- ☐ An eligible individual or dependent loses minimum essential coverage; pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per calendar year), or the eligible individual or dependent is enrolled in any non-calendar year group health plan or individual health insurance policy that will expire in the current Policy year (even if they have the option to renew the expiring policy). Note: the special enrollment period for these triggering events starts 60 days before such coverage ends and extends until 60 days after such coverage ends;
- ☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours;
- ☐ An eligible individual gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order, or other court order;
- ☐ An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee;
- ☐ An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan;
- ☐ An eligible individual gains access to new health plans as a result of a permanent move.

For any Special Enrollment Period reason, provide:

Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

Select Desired Medical Benefit Plan:	Select Desired Dental Benefit Plan:		
☐ Cigna Access HSA Bronze 6000	☐ Cigna Dental Preventive	Primary:	☐ Medical ☐ Dental
☐ Cigna Access HSA Silver 2750	☐ Cigna Dental 1000	Spouse (or Domestic Partner/Civil Union):	☐ Medical ☐ Dental
☐ Cigna Access Flex Gold 1000	☐ Cigna Dental 1500	Dependent 1:	☐ Medical ☐ Dental
		Dependent 2:	☐ Medical ☐ Dental

Section D. Applicant, Spouse and Dependent Information

Applicant's Last Name:	First Name:	M.I.	Social Security Number:	iTIN:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Custodial Parent or Legal Guardian Name (for applicants under the age of 18):	Relationship to Applicant:

Mailing Address – Home Address Required	Billing Address – If different than mailing address	County	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) _____-_____
Street	P.O. Box / Street		
City State	City State		
ZIP Code (Please provide 9-digit ZIP Code)	ZIP Code		Email Address:

Applicant's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Spouse/Domestic Partner/Civil Union's Last Name	First Name	M.I.	Social Security Number	iTIN:

Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Spouse/Domestic Partner/Civil Union's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent children are covered up to age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Dependent's Last Name	First Name	M.I.	Social Security Number	iTIN:

Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent's Last Name	First Name	M.I.	Social Security Number	iTIN:

Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

D1. Are all enrollees residents of the United States? ☐Yes ☐No
If you answered "No" to the above question, provide names of non residents:
_____

D2. Do all enrollees reside within Maryland and within the service area of the selected benefit plan? ☐Yes ☐No
If you answered "No" to the above question, provide names of non residents:
_____

Cigna Health and Life Insurance Company Use Only:	Effective Date:

Section E. Current Coverage and Additional Prior Coverage Information

E1. Does any applicant(s) have current health care coverage? ☐Yes ☐No

E2. If any applicant answered "Yes" to any of the above, please provide the following information:
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination Date: _____

E3. Does this information apply to all family members on this application? ☐Yes ☐No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

E4. Does any applicant(s) have current dental care coverage? ☐Yes ☐No

E5. If any applicant answered "Yes" to any of the above, please provide the following information:
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination Date: _____

E6. Does this information apply to all family members on this application? ☐Yes ☐No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Section F. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Please do not cancel other current health insurance coverage until written notification is received from Cigna Health and Life Insurance Company indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Section G. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged only upon approval of your Application.

Initial Premium Payment Method:

☐ Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check

Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT both for my initial payment and for ongoing monthly payments (no paper or electronic monthly billing statement will be issued).

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna Health and Life Insurance Company) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

Credit Card (Available for initial payment only) ☐ VISA ☐ MASTERCARD

Cardholder's Name – exactly as it appears on the card:

Account Number:

☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Account Holder's ZIP Code: ____ ____ ____ ____ ____ – ____ ____ ____ ____ 3-digit Code: ____ ____ ____

Card Expiration Date:

Any premium adjustment will automatically be charged to your account.
Please be advised that the premium adjustment may reflect an increase.

For Paper Application: ***Please check here:*** ☐ Paper check is attached or ☐ Credit card information provided.

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the credit card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) *Please complete the EFT section above.*

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in Section D of this application.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Section H. Statement of Accountability – *To be completed when applicant cannot complete the application.*

I, _____, personally read and completed this Enrollment Application Form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application disclosed by:

_____

I also personally translated and fully explained the Conditions and Agreement Section:

_____ _____

Signature of Translator *required* *(Excludes Parent Signature if Child Only Application)*

Today's Date *required*

Section I. Producer Section

Writing Producer Name:		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Are you aware of any information about your client not disclosed on this application?		☐ Yes ☐ No
Did you see the proposed applicant at the time this application was completed? If "No", please explain:_____		☐ Yes ☐ No

I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.

Signature of Writing Producer:		Date:
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer.		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Sales Representative Last Name:		First Name:

Section J. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Health and Life Insurance Company Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 877.484.5927
www.Cigna.com

Section K. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna Health and Life Insurance Company within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company.
- Effective dates are generally assigned to the 1st of the month. The next available effective date will be assigned, if not selected by the applicant.

Section L. Conditions and Agreement/Authorization

1. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
2. I authorize that payment be made under Part B of Medicare to Cigna Health and Life Insurance Company for medical and other services furnished by Cigna Health and Life Insurance Company for which it pays or has paid, if applicable.
3. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, or other payments source Cigna Health and Life Insurance Company may be authorized by applicable law to pursue, to fully inform Cigna Health and Life Insurance Company and execute such documents and provide such assistance as may be necessary to enable Cigna Health and Life Insurance Company to recover the value of services provided, arranged or covered.
4. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
5. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the receipient and will no longer be protected by federal privacy regulations.
6. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).

If a social security number is not provided on this application, Cigna Health and Life Insurance Company will issue a Cigna Health and Life Insurance Company assigned identification number to identify our plan members. Risks associated with the use of an assigned identification number include the following: 1) the possibility exists that the assigned identification number may match another individual's Social Security number or an assigned identification number issued by another company; and 2) use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted, and (b) a contract has been issued by Cigna Health and Life Insurance Company.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM.

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna Health and Life Insurance Company benefit plan. I acknowledge and agree that any fraudulent misrepresentation of any applicant will render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna Health and Life Insurance Company will refund all amounts paid by me except amounts owed to Cigna Health and Life Insurance Company.

Applicant Signature:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):	Today's Date: (MM/DD/YYYY)